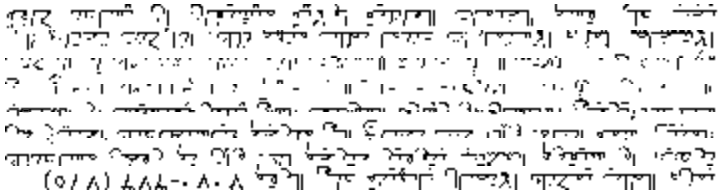
ASSISTANCE APPLICATION

State of Michigan
Family Independence Agency

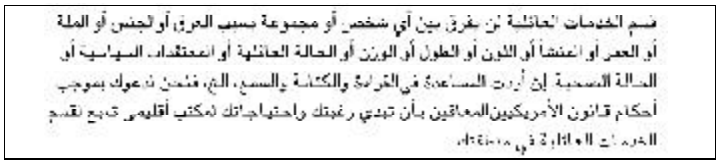
HELP IS AVAILABLE

THE FAMILY INDEPENDENCE AGENCY MUST HELP ALL PERSONS FILL OUT THE APPLICATION, WHEN REQUESTED. IF YOU NEED HELP, PLEASE CALL OR VISIT YOUR SPECIALIST OR THE OFFICE NAMED BELOW. IF YOU NEED AN INTERPRETER, YOU MAY USE ONE OF YOUR CHOICE OR THE AGENCY WILL PROVIDE ONE. IF YOU ARE REFUSED HELP IN FILLING OUT THE APPLICATION, YOU MAY CALL (517) 373-0707.

LA FAMILY INDEPENDENCE AGENCY DEBE AYUDAR A TODAS LAS PERSONAS A COMPLETAR LA APLICACIÓN CUANDO ASÍ LO PIDEN. SI UD. NECESITA AYUDA, POR FAVOR LLAME O VISITE A SU TRABAJADOR O LA OFICINA QUE SE MENCIONA ABAJO. SI NECESITA UN INTÉRPRETE, UD. PUEDE USAR UNO DE SU ELECCIÓN O LA AGENCIA LE PROPORCIONARA UNO. SI UD. ES NEGADO AYUDA PARA COMPLETAR LA APLICACIÓN, PUEDE LLAMAR AL (517) 373-0707.



Family Independence Agency (FIA) no discrimina contra ningún individuo o grupo a causa de su raza, sexo, religión, edad, origen nacional, color de piel, estatura, peso, estado matrimonial, creencias políticas o incapacidad. Si Ud. necesita ayuda para leer, escribir, oír, etc., bajo la Acta de Americanos con Incapacidades, usted esta invitado a hacer saber sus necesidades conocidas a una oficina de FIA en su condado.



PLEASE READ CAREFULLY

You have the right to file an application today or at any time, including prior to any interview or appointment. The date you file may affect the amount of benefits you receive. Your application must be approved or denied within the following standards:

- Family Independence Program (FIP)..... 45 days
- State Disability Assistance (SDA) ..... 60 days
- State Medical Program (SMP)..... 45 days
- State Emergency Relief (SER) ..... 10 days
- Food Assistance Benefits (FA)..... 30 days
- Expedited Food Assistance Benefits (FA) 7 days
- Medical Assistance (MA) ..... 45 days
  except disability-related MA is ..... 60 days
- Refugee Assistance Program (RAP) -
  Cash Assistance ..... 30 days
- Refugee Assistance Program (RAP)
  Medical Aid ..... 45 days
- Repatriate Assistance Program (REP)..... 45 days
- Child Development and Care (CDC)..... 45 days

This form is issued under authority of 42 CFR 435.907; 7 CFR 273.2(d); and Sections 25 and 59 of Act 280 of the Public Acts of 1939, as amended. You must complete this form if you want the agency to consider your application for financial or medical assistance or food stamps.

The Family Independence Agency will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to an FIA office in your county.

You must complete the entire application to have your eligibility determined.

If you cannot complete the entire application today, you can file today for assistance and begin these time periods by providing the following information:

- Your name,
- Your birthdate,
- Your address (homeless persons do not have to list an address), **and**
- Your signature or your representative's signature.

If you wish to do this, ask the receptionist for a filing document (FIA-1171-F).

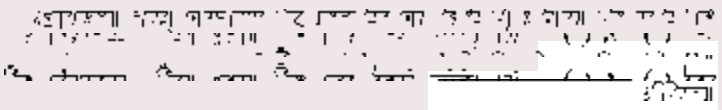
Then, return the filing document to the receptionist to establish your filing date.

Exception: If you are applying for Supplemental Security Income (SSI) and Food Assistance benefits before being released from a medical institution, the filing date of your application will be the date of your release from the institution.

LOCAL OFFICE:

Do you need the Agency to provide an interpreter to help you at the interview? ( ) yes ( ) no If yes, what language? _____

¿Necesita que le proporcione un intérprete para que le ayude en la entrevista? ( ) si ( ) no
Si dice que sí, ¿que idioma hablan en su casa? _____



FOR OFFICE USE ONLY

Grantee Name				
Grantee Client ID				
Case Number				
County	District	Section	Unit	Specialist

APPLICANT INFORMATION. PLEASE PRINT

1. Name (First, Middle, Last)	2. Date of Birth (Mo/Day/Yr)	3. Phone Number ( )

4. Residence Address (Number, Street, Rural Route, Apt. No.)	City	County	State	Zip code

5. Mailing Address (If Different From Above)	City	County	State	Zip code

6. Directions to Home

7. If anyone in your home uses a teletype for the deaf, enter TDD or TTY Number: ( )	8. Name of person and phone number where you can be reached. Name (First, Last)	Phone No. ( )

9. Is your household homeless? ..... ☐ Yes ☐ No

10. Do you and/or your household intend to stay in Michigan? ..... ☐ Yes ☐ No

11. Have you and/or your household come to Michigan looking for work or with a job commitment? ..... ☐ Yes ☐ No

12. Have you moved here or received money or benefits (Cash Assistance, Food Stamps, Medical Assistance, etc.) **from another state** since August of 1996? ..... ☐ Yes ☐ No

13. If yes, what state? _____ County: _____ When did you move? _____ Worker phone number: ( ) _____

14. Check the Programs you are applying for

☐ Cash Assistance (rent and other daily living expenses)
☐ Medical Assistance (doctor bills, hospital bills, prescriptions, Medicare premiums)
☐ Food Assistance Benefits (food)
☐ State Emergency Relief (utility shut-off, eviction notice, or other emergency)
☐ Child Development and Care (CDC, child care payments)

15. If you live in a nursing home or institution, name of nursing home or Institution:	Phone Number ( )	Expected date of release:

Address (number, street, rural route, apt. no.)	City	State	Zip code

16. If you have a court-appointed guardian or conservator, name of guardian or conservator:	Do you pay guardian/conservator expenses? ☐ Yes ☐ No	Phone number ( )

Address (number, street, rural route, apt. no.)	City	State	Zip code

17. Have you ever applied for, or received, assistance from the State of Michigan? .... ☐ Yes ☐ No

18 - 27 for FA Only

18. If you are eligible for Food Assistance and want someone else to pick them up or shop for you, enter the name of an authorized representative:

19. If you have received Food Assistance benefits before, do you still have your Bridge Card(s)? ..... ☐ Yes ☐ No

20. What is the total amount of CASH assets belonging to your household? (Include cash, savings, checking, savings bonds, etc.) $ _____

21. What is the total INCOME your household will receive this month? (Include earnings, UCB, child support, Social Security benefits, etc.) $_____

22. What is the total amount of your monthly rent and/or mortgage payment? $_____

23. Do you pay for heat? ☐ Yes ☐ No
If you do not pay for heat check utilities you pay for ☐ non heat electric
☐ water/sewer ☐ telephone ☐ cooking fuel ☐ garbage/trash

24. Is anyone in your household a migrant or seasonal farmworker? ☐ Yes ☐ No
If **YES**, please answer questions 25 through 27.
If **NO**, skip to 28.

25. Has anyone in your household received any income this month? ☐ Yes ☐ No
If YES, how much? $_____ When? _____

26. Did your household recently lose its only source of income? ☐ Yes ☐ No
If YES, when? _____

27. Does anyone in your household expect to receive income this month? ☐ Yes ☐ No
If YES, how much? $_____
When? _____
Any travel advance? ☐ Yes ☐ No

28. If you are applying for someone else, complete the following information:

Name (First, Middle, Last)	Relationship	Phone Number ( )

Address (Number, Street, Rural Route, Apt. No.)	City	State	Zip code

1. ANSWER ALL QUESTIONS LISTED BELOW

- **List yourself first and then all other persons who live in the home or are temporarily absent from your home.**
- **If you are applying for a patient in a nursing home, list the patient first, then the patient's spouse and other dependents at home, if any.**

Enter this person's racial heritage from the codes below. If you are multiracial, you may enter all codes that apply. (Answering this is voluntary.)

W = White
B = Black
S = Asian
I = American Indian
A = Alaskan Native
P = Native Hawaiian or Pacific Islander

Check box below if you are Hispanic or Latino. (Answering this is voluntary.)

Line No.	NAME (First, Middle, Last)	Do you want benefits for this person? Yes	No	Relationship to you	Date of birth Mo / Day / Year	Social security number for those applying for assistance	Sex M or F		☐
1				SELF					☐
2									☐
3									☐
4									☐
5									☐
6									☐
7									☐
8									☐

2. Is any person listed above under the age of 18 **and** the parent of a child listed? ☐ Yes ☐ No ▶ If yes, enter the following:
Person's name: Child's name:

3. Is any child listed above under the age of 3 months? ☐ Yes ☐ No ▶ If yes, enter the following:
Child's name: Mother's name:

4. Is any person :	Yes	No	If yes, Who?	Who?	Who?	Who?
Attending school						
Disabled, blind or unable to work						
Caring for a disabled child or spouse						
A refugee						
A migrant						
Pregnant				Due Date		Due Date
Expecting more than one child?	☐ Yes	☐ No	If yes, how many?		☐ Yes ☐ No If yes, how many?	

5. Is anyone in the home other than a parent acting as the parent to a person under 21 years of age? ☐ Yes ☐ No If yes, enter name of person: _____ and child's name: _____

6. Is each person applying for assistance a U.S. Citizen? ☐ Yes ☐ No Complete the information for each applicant who is NOT a U.S. Citizen.	Name and date of US entry	Name and date of US entry	Name and date of US entry	Name and date of US entry

7. Is anyone in your household an alien who was sponsored for admission into the U.S.? ☐ Yes, who? _____ ☐ No

EMPLOYMENT AND TRAINING	Yes	No	If Yes, who?
8. Is any person participating in a strike?			
9. Will any person begin a job before the end of the next calendar month?			
10. In the last 60 days has anyone: refused work, reduced the number of hours worked, quit a job, been laid off, or been fired?			

ADDITIONAL INFORMATION	Yes	No	If Yes, who?
11. Is any person a U.S. armed forces veteran or widow, spouse, child or mother of a U.S. veteran?			
12. Is any person a fugitive felon? (answering this is voluntary if you are applying only for Medical Assistance.)			
13. Has any person ever been convicted of a felony for the possession, use or distribution of a controlled substance (drugs) occurring after August 22, 1996? (answering this is voluntary if you are applying only for Medical Assistance.)			
14. Does anyone applying have a husband or wife who is living someplace else?			
15. Are all children under 6 years of age up to date on their immunizations (shots)?			If No, who is not?
16. Do you or anyone in your home receive tribal food commodities?			If Yes, who?

Line No.	Enter this person's marital status using the codes below: M — Married N — Never Married D — Divorced S — Separated W — Widowed	Enter the date of marriage. Mo/Day/Yr	Does each person in the home buy, fix or eat food with person #1? Yes	No	What was the highest school grade this person completed? (Use 13, 14, etc. for years past high school.)	**Answer these questions for each person under 21 years old.** A Enter the name of this person's father. Name	B Is this person's father in the home? Yes	No	C If B is NO, is this person's father dead? Yes	No	D If B and C are NO, were the parents married to each other? Yes	No	E If B, C & D are NO, was paternity legally established? Yes	No	F Enter the name of this person's mother. Name	G Is this person's mother in the home? Yes	No	H If G is NO, is this person's mother dead? Yes	No
1			SELF																
2																			
3																			
4																			
5																			
6																			
7																			
8																			

17. If you need, or currently pay for, child care services, check why and explain. ▶
If applying for Food Assistance only, do not complete D or G.

☐ Work ☐ High school completion ☐ Health/social reasons
☐ Michigan Works! Agency (MWA) or other approved education or training (includes approved post-secondary education)

A. Name of child needing care	B. Age	C. Cost of care and how often paid	D. Is provider related to child? How?	E. Name and address of care provider	F. Provider phone number	G. Provider ID Number

18. Is care provided in the home where the child lives?
☐ Yes ☐ No

19. Are you a foster parent to a child needing care?
☐ Yes ☐ No ▶ If yes, Who?

EMPLOYMENT INCOME

20. Is any person employed or self-employed, including odd jobs.

☐ Yes ☐ No ▶ If yes, and self employed, complete Section 21. All other yes responses, complete earned income on page 4. Include employment of all household members.

SELF-EMPLOYMENT

21. Name of self-employed person	22. Gross monthly income, minus allowable federal tax deductions (DEPRECIATION not allowed)	23. Is health insurance offered by business?	If Yes, enter amount of monthly premium, even if you are not covered by the insurance.	24. Type of business
	$ per/month	☐ Yes ☐ No	▶	
	$ per/month	☐ Yes ☐ No	▶	

EARNED INCOME: (Answer All Questions)

Name of person with earnings	Start date	Will employment continue
		☐ Yes ☐ No

Is health insurance offered by your employer? ☐ Yes ☐ No If yes, ▶	Enter the amount of monthly premiums even if you are not covered by the insurance $

Employer Name	Monthly pay before taxes.	Monthly take home pay after taxes.
	$_____ (tips included)	$_____ (tips included)

Average number of hours per week	How often paid (length of pay period)	Day of week paid	Last pay date	
	☐ Weekly ☐ Twice a month ☐ Every other week ☐ Other			

Rate of Pay	Tips/bonus received?	Tips included in gross income on check stub?	Average amount for tips
$_____ Hourly $_____ Salary $_____ Other	☐ Yes ☐ No	☐ Yes ☐ No	$_____ / hour $_____ / week

Name of person with earnings	Start date	Will employment continue
		☐ Yes ☐ No

Is health insurance offered by your employer? ☐ Yes ☐ No If yes, ▶	Enter the amount of monthly premiums even if you are not covered by the insurance $

Employer Name	Monthly pay before taxes.	Monthly take home pay after taxes.
	$_____ (tips included)	$_____ (tips included)

Average number of hours per week	How often paid (length of pay period)	Day of week paid	Last pay date	
	☐ Weekly ☐ Twice a month ☐ Every other week ☐ Other			

Rate of pay	Tips/bonus received?	Tips included in gross income on check stub?	Average amount for tips
$_____ Hourly $_____ Salary $_____ Other	☐ Yes ☐ No	☐ Yes ☐ No	$_____ / hour $_____ / week

Name of person with earnings	Start date	Will employment continue
		☐ Yes ☐ No

Is health insurance offered by your employer? ☐ Yes ☐ No If yes, ▶	Enter the amount of monthly premiums even if you are not covered by the insurance $

Employer Name	Monthly pay before taxes.	Monthly take home pay after taxes.
	$_____ (tips included)	$_____ (tips included)

Average number of hours per week	How often paid (length of pay period)	Day of week paid	Last pay date	
	☐ Weekly ☐ Twice a month ☐ Every other week ☐ Other			

Rate of Pay	Tips/bonus received?	Tips included in gross income on check stub?	Average amount for tips
$_____ Hourly $_____ Salary $_____ Other	☐ Yes ☐ No	☐ Yes ☐ No	$_____ / hour $_____ / week

OTHER INCOME:

Does anyone receive money from:	Yes	No	If Yes, who receives?	Monthly amount	Claim #	If Yes, who receives?	Monthly amount	Claim #
Social Security Benefits (RSDI)						▶		
Supplemental Security Income (SSI)						▶		
Veterans benefits						▶		
How Often Paid W = Weekly M = Monthly T = Twice a Month E = Every Other Week O = Other _____					How often paid?			How often paid?
Workers Compensation						▶		
Disability benefits						▶		
Child support						▶		
Unemployment compensation						▶		
Retirement benefits						▶		
Military allotments						▶		
Gaming distributions (Casino profit sharing)						▶		
Is there any other income? Please specify						▶		

If you are applying for Food Assistance or Child Development and Care only do not complete this page.

ASSETS: Complete this section by providing requested asset information, including assets held jointly.

Does any person have any of the following:	Yes	No	Name(s) on the account	Name and address of bank, credit union, savings and loan	Account number	Balance
• Checking/Draft Accounts						
• Money Market Accounts						
• Savings/Share Accounts						
• Certificates of Deposit (C.D.)						
• Christmas Club Accounts						
• Patient Trust Fund						

Does any person have any of the following:	Yes	No	If Yes, give amount/value	Owner(s)	If Yes, give amount/value	Owner(s)
• Cash on hand or in safe deposit box						
• Real Estate (not including place you live) including income-producing and non-income-producing property						
• Mortgage, Land Contract or other notes payable to household member						
• Savings Bonds, Stocks or Mutual Funds						
• IRA, KEOGH, 401K or Deferred Compensation Account(s)						
• Trust funds						
• Life estate						
• Tools and equipment, livestock or crops						
• Life insurance or annuity						
• Burial plot(s), Casket, etc.						
• Burial Trust Funds/funeral contract(s)						
• Are there any other assets? Please specify						

ADDITIONAL ASSET INFORMATION

Has any person sold or given away property, land, vehicles, stocks, bonds, savings, cash, checking, income, etc., closed any accounts or removed or added a name on any asset within the last 36 months?	Have you, or has anyone who lives with you, received a one-time cash payment (such as worker's compensation, lottery winnings, insurance settlement, lawsuit award, etc.) within the last 36 months?
☐ Yes ☐ No If yes, Who? _____	☐ Yes ☐ No If yes, Who? _____
Do you, or does any person living with you, have a pending lawsuit which may bring him/her money, property, etc.?	Have you, or has anyone living with you, or has anyone acting for any household member, ever put any money, lawsuit settlement, income or assets in a trust, annuity or similar legal device?
☐ Yes ☐ No If yes, Who? _____	☐ Yes ☐ No If yes, Who? _____

VEHICLE INFORMATION — List all vehicles owned or titled in the name of any person living in the home. Include vehicles owned jointly.

Name of vehicle owner(s) (As shown on vehicle title or registration)	Type of vehicle	Year	Make/ Model	Amount owed

If you are applying for Child Development and Care only, do not complete this page. Go to page 7.

SHELTER (HOUSING) EXPENSES	Yes	No	Amount Paid Per Month
1. Does any person have a rent, mortgage or other shelter expense?			
2. Does any person have a second mortgage or home equity loan as part of their shelter expense?			
3. Do you live in HUD, Section 8, MSHDA subsidized housing?			
4. Do you have any of the following expenses separate from rent or mortgage?			
• Homeowner's insurance			Per Yr
• Property Taxes			Per Yr
• Mortgage Guarantee Insurance			
• Cooperative/condominium/or association fee			
• Special Assessments			
• Renter's Insurance			Per Yr
• Mobile Home Lot Rent			
5. Do you or does your household share shelter expenses?			

HEAT AND UTILITY EXPENSES	Yes	No	Amount you pay Per Month
6. Do you have any of the following expenses separate from rent or mortgage?			
• Heat (gas, electric, propane, wood, etc).			
• Electricity (non-heat)			
• Water/Sewer			
• Telephone			
• Cooking Fuel			
• Garbage/Trash Pick up			
• Other (write in):			
7. Does any person receive or expect to receive, a home heating credit from the Michigan Department of Treasury?			

OTHER LIVING ARRANGEMENTS	Yes	No	Amount you pay Per Month
8. Do you pay anyone you live with for:			
• Rent and meals			
• Rent only			
• Meals only			
9. Do you live in a commercial boarding house?			
10. Do you live in:			
• A drug or alcohol abuse treatment center			
• An adult foster care home			
• A home for the aged			
• A county infirmary			
• A shelter for battered women			
• An emergency shelter			

OTHER EXPENSES	Yes	No	Amount You Pay Per Month
11. Does any person pay court-ordered child support or alimony?			
If yes, who pays?			

MEDICAL INFORMATION	Yes	No	Amount You Pay Per Month
12. Does any person have any of the following medical expenses:			
• Medical/Dental care			
• Prescription drugs			
• Prescribed over-the-counter drugs			
• Hospitalization or nursing home care			
• Dentures/hearing aids/eyeglasses			
• Prosthetics			
• Seeing eye/hearing dog			
• Transportation for medical care			
• Personal care/chore services			

13. Is any person covered, or was any person covered in the last 3 months by:	Yes	No	If Yes, enter current monthly premium you pay.
• Medicare			
Claim # _____			
• An employer's group health plan			
• A health or hospital insurance policy other than Medicaid			

Do Not complete Items 14-21 if applying for FA Only.

	Yes	No	If Yes, Who?
14. Does any person have unpaid medical expenses for services provided in the last 3 months?			
15. Does any person pay for transportation to receive medical care for pregnancy or an ongoing medical problem?			
16. Does any person go to an alcohol or drug treatment program?			
17. Has any person set up a plan or entered into a contract, such as a life care contract, that will pay for his/her medical care?			
18. Has any person had an accident or work-related illness or injury resulting in medical costs that may be paid by another person or an insurance company?			
19. Has any person applied for benefits from the Social Security Administration?			
20. If yes to above question, answer questions (a-d).	Yes	No	If Yes, When?
a. Has this person been denied SSI benefits because the Social Security Administration decided he/she is not disabled?			
b. If yes to question a, has the SSI denial been appealed?			
c. If yes to question a, has this person's health condition changed?			
d. If yes to c, check appropriate change ☐ Different impairment ☐ Additional impairment ☐ Impairment worsened			
21. Has anyone ever attended or is anyone now attending a special education class?	Yes	No	If Yes, Who?

ASSIGNMENT OF BENEFITS

Support Payments.

I understand that, as a condition of eligibility for the Family Independence Program, I am assigning to the Family Independence Agency any rights to support I may have from another person for myself or any person for whom I am applying or receiving assistance. This assignment includes rights to present and future support, as well as support owed to me from past periods. Such payments will be used to reimburse the Agency up to the amount of assistance granted.

Recovery of Medical Costs.

I understand that when the Michigan Department of Community Health (MDCH) pays the cost of hospital, surgical, or medical services, any right to recover costs from a third person or public or private contractor, except Medicare, is transferred to the MDCH. Payment of any recovery under such right is to be made directly to the State of Michigan — MDCH.

Supplemental Security Income (SSI) Payments.

I authorize the Social Security Administration to make my first Supplemental Security Income (SSI) payment to the Family Independence Agency (FIA), if I file an SSI claim for up to one year after the date this application is received by FIA. I further permit the FIA to deduct from such first payment an amount that is enough to pay back my interim assistance. After keeping such amount, the FIA shall promptly pay the balance, if any, to me. I understand that I have the right to a hearing from the FIA if I disagree with the amount deducted from the first payment. Interim assistance means State Disability Assistance money paid to meet my basic needs, excluding assistance payments financed wholly or partly with federal funds, while my SSI claim is pending. If I receive the first SSI benefits payment directly, I agree to pay the FIA promptly for any interim assistance advanced while the claim for SSI was pending. This release is **not** to be regarded by the Social Security Administration (SSA) as an intent to file for SSI unless I actually file a claim for SSI, on a prescribed form, within 60 days.

RELEASES

Social Security Information.

I authorize the Social Security Administration to give to the Family Independence Agency all information necessary to determine my eligibility for benefits under the Family Independence Program, Medicaid, Food Stamps, Child Development and Care, State Disability Assistance, or State medical programs until the second month following the expiration of my eligibility based on the current application.

Child Support Payment Information

I authorize release of child support payment information from the Michigan Child Support Enforcement System for myself or for any person for whom I am applying for or receiving assistance for under the Family Independence Program, Medicaid, Food Assistance, Child Development and Care, State Disability or state medical programs.

Charitable Groups.

I authorize the Agency to give my name, the first name(s) and age(s) of the child(ren) living with me, and my address when requested by a charitable group whose purpose is to provide goods or services to my household. The group must be known to FIA staff for its charitable work. The information given to the group cannot be used for personal, political, commercial or religious reasons.

Child Development and Care.

I authorize the Agency to send notices and/or provide information to my child care provider(s) when: 1) child care services have been authorized, or 2) when there are changes in the authorization information previously given to the provider, or 3) my application for Child Development and Care (CDC) services is denied or withdrawn, or 4) my CDC case is cancelled. I also authorize the Agency or any child care center that may provide care for my child(ren) to release information necessary to determine my right to benefits under any local, state or federal program.

Eligibility Information.

I understand that the information I have provided will be used to make sure my household is eligible for Food Stamp benefits, other federal and state assistance programs, and federally assisted state programs such as school lunch, Family Independence Program, and Medicaid. Fraudulent participation in the Food Stamp Program may result in criminal or civil action or administrative claims. I understand that this application may be chosen for further Agency investigation.

AFFIDAVIT

I certify, under penalty of perjury, that all the information that I have written on this form or told to a specialist is true. I understand that I can be prosecuted for perjury if I have intentionally given false information. I also know that I may be asked to show proof of any information I have given. I also know that if I have intentionally left out any information or if I have given false information, which causes me to receive assistance I am **not** entitled to or more assistance than I am entitled to, I can be prosecuted for fraud and/or required to repay the amount wrongfully received.

IMPORTANT: YOU MUST SIGN THE APPLICATION

I certify that I have received and reviewed a copy of the Acknowledgments, that explains additional information about applying for and receiving assistance benefits.

Signatures: Customer or Representative	Date	Agency Witness (when in-person interview completed)	Load #	Date
Signature of Migrant Recruiter	Date	Migrant Recruiter Address		

FOR OFFICE USE ONLY

NOTES

PLEASE KEEP THIS PAGE.

INFORMATION ABOUT MEDICAID

Rules may have changed since this was printed. Check with your local FIA office.

Medicaid helps people pay for medical care. A person may have Medicare, Health Insurance, and Medicaid. Medicaid may help with expenses not paid by Medicare or Health Insurance. If you need help with past, unpaid medical expenses, your coverage may begin three months before you apply.

Who May Receive Medicaid

a. A Family Independence Program (FIP) recipient.
b. A Supplemental Security Income (SSI) recipient.
c. Anyone who is financially eligible and is:

- under age 21,
- pregnant,
- age 65 or older,
- blind or disabled, or
- a parent or close relative living with a child. The child must be under age 18, or age 18 or 19 in high school full-time and expected to graduate before age 20.

Assets

There is a limit on assets for Medicaid categories that are based on age (65 or older), disability or blindness. Countable assets must be at or below the asset limit at least part of each month for which Medicaid is requested. If your assets are more than the asset limit, you may become eligible for Medicaid if you use your excess assets to pay some of your medical bills, living expenses, or other debts. You may be asked to verify when and for what purposes you used your excess assets.

Income

Income is compared to an income allowance based on family size. The allowance varies across Michigan. If your monthly income is above the allowance, help may still be available depending on your medical expenses.

Medicaid Publications

In addition to being financially eligible, a person must meet other requirements, such as being a Michigan resident and providing a social security number. For more information about income, assets and other requirements, ask for the appropriate publication(s) listed on the next page.

PUBLICATIONS

If you would like information about FIP, ask for the following publication:

- FIA Publication 179 - Family Independence Program

If you would like information about Food Assistance benefits, ask for the following publications:

- FIA Publication 16 - Food Assistance in Michigan

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If you would like information about Medicaid, ask for the following publications:

- MSA Publication 141- Facts About Medicaid: explains basic Medicaid eligibility rules.
- MSA Publication - Healthy Kids Free Health Care Coverage for Pregnant Women, Babies, and Children: explains medical coverage for pregnant women and children.
- DCH Publication 726 - Nursing Home Eligibility: explains eligibility for nursing home patients.
- MDCH Publication 769 - Get the most out of life by getting the most out of health care: explains eligibility for Medicare Savings Programs.
- MSA Publication 617 - Medicaid Spend-Down Information: explains the income spend-down process.

If you would like information about Child Development and Care, ask for the following publications:

- FIA Publication 626 - Accreditation: Added Security When Choosing Child Care
- FIA Publication 798 - Michigan Cares for Today's Child
- FIA Publication 836 - 4 Steps to Choosing Quality Child Care - A Parent's Checklist

If you would like information on establishing paternity (establishing a legal father for a child born to an unwed mother) or child support services, ask for the following publications:

- FIA Publication 780 - What Every Parent Should Know About Establishing Paternity
- FIA Publication 865 - DNA Paternity Testing: Questions and Answers
- FIA Publication 748 - Understanding Child Support. A Handbook for Parents

FOOD ASSISTANCE BENEFITS — 7 - DAY PROCESSING

Your household may qualify for 7-day processing of your Food Assistance application. This faster service is available if:

- you have less than $150 in monthly gross income and $100 or less in liquid assets (cash on hand, checking or savings accounts, savings certificates), **or**
- your combined gross income and liquid assets are less than your monthly rent and/or mortgage payment plus heat and utilities, **or**
- you are a **destitute*** migrant or seasonal farmworker with less than $100 in liquid assets.

  * **Destitute** means that your income **has stopped** before the date of your application, or your income **has started** but you expect to receive no more than $25 within the next 10 days.

If your household qualifies for 7-day processing, you will need to:

- participate in an interview, **and**
- provide proof of your identity, **and**
- complete the entire application process.

To continue receiving Food Assistance benefits, you will be asked to provide proof of other information, such as income, residency, etc. If you can provide those proofs today, you may be given a longer Food Assistance benefit period.

MORE ABOUT FOOD ASSISTANCE BENEFITS

A face-to-face interview may be waived and replaced by a telephone interview if household hardships exist. These hardship conditions include, but are not limited to: illness, transportation difficulties or work hours which prevent participation in an in-office interview. Contact your specialist if you believe a telephone interview is necessary.

To receive a deduction for the following expenses, you must report and provide any required verification to your Specialist of:

- Child Care expenses
- Rent or mortgage payment
- Medical expenses
- Heat and utility or other shelter costs
- Child support paid to a non-household member

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Failure to report or verify any of the above listed expenses will be seen as a statement by your household that you do **not** want to receive a deduction for the unreported expense. If your heat is included in your rent, and you receive or expect to receive the Home Heating Credit and you do **not** fill out question 7 on page 6, this will be a statement that you do not want to receive a deduction for heat expenses.

FOOD ASSISTANCE (FA) WORK REQUIREMENTS

The following section describes the work requirements for FA-only households. An FA-only recipient does not have to participate in work-related activities unless receiving Time-Limited Food Assistance (see last paragraph).

Adults who are working and who are not deferred or do not have good cause (see below) may not:

- Voluntarily quit a job of 20 hours or more per week.
- Voluntarily reduce hours of employment below 30 hours per week.
- Be fired from a job for misconduct or absenteeism (except for incompetence).

Note: No penalty applies if the job quit, reduction in hours or firing occurred more than 30 days before your application date for FA.

Adults who are not working or are working less than 30 hours per week (unless deferred) must:

- Accept a legitimate offer of employment.
- Participate in employment-related activities that are required of an individual in order to receive unemployment compensation.

Your FA can be reduced or closed if an adult in your household does not comply with any of these work requirements without good cause. The first time you do not comply, the adult will be removed from your FA group for one month or until he or she complies with the work requirements, whichever is longer. After the first time, the adult will be removed from the FA group for six months or until they comply with the requirements, whichever is longer.
Note: If you receive Food Assistance (FA) benefits in addition to Family Independence Program (FIP) benefits, you must follow the work requirements for the FIP program.

Deferral and Good Cause Criteria

The work requirements do not apply to you if you are deferred. You may be deferred if you are:

- Under age 16 or age 60 or older
- Personally providing care for a child under age 6 who is a member of your FA group
- Incapacitated due to injury, physical illness or mental illness
- Disabled or personally providing care for a disabled member of your FA group
- Attending High School or a GED preparation program
- A pregnant woman who has medically documented complications **or** is beginning the 6th month of pregnancy.
- Applying for both SSI and FA through the Social Security Administration
- Participating in a substance abuse treatment or rehabilitation program (This does not include Alcoholics Anonymous or Narcotics Anonymous group meetings)
- Applying for, receiving or appealing the denial of unemployment compensation

Let your specialist know as soon as possible if you have a good reason for not following FA work requirements, such as you did not have child care or transportation, or you or your child were ill. Your FA will not be reduced if you have "good cause" for not complying with a work rule.

Voluntary Employment, Education and Training Opportunities

Employment services may be available if you are looking for a job or want to find a better job. There may be education and job training programs available in our area. Participating in some of these programs may also meet FA work requirements. Ask your FIA specialist or local Michigan Works! Agency to tell you about voluntary education and job training programs that are available.

TIME-LIMITED FOOD ASSISTANCE

Special work requirements and time limits apply if you are not deferred from FA work requirements and are an able bodied (not disabled) adult who is at least 18 years old and less than 50 years old, and have no children living in your home (related or unrelated). Your specialist will give you a "Time Limited Food Assistance Notice" that explains these requirements. If you have questions, be sure to contact your specialist.

All information will be kept confidential.

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ACKNOWLEDGMENTS

State of Michigan
Family Independence Agency

This is your copy of your rights and responsibilities as an applicant for or recipient of assistance benefits. By signing the application you acknowledge that you understand your rights and responsibilities.

1. **Non-discrimination**. In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs.

   To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). USDA and HHS are equal opportunity providers and employers.

2. **Reporting Changes**. I understand that the agency needs to know of any changes in income or assets of all persons listed on the application form. I will report any change in my living arrangement, such as address change, persons coming to live with me or leaving home, getting married, and so on. I will tell the agency of a change **within ten days** of the change. I understand that if I intentionally do **not** do this, I can be prosecuted for fraud or perjury.

   If I begin employment, I must report this within 10 days of my start date.

   The types of changes that must be reported **within ten days** of the date I first know about them are:

   - Employment starts or stops
   - Change of employer
   - Change in rate of pay
   - Hours of work change by more than 5 hours per week if it will last more than one month.
   - Unearned income starts or stops (examples: Social Security, pension, unemployment and retirement)
   - Unearned income changes by more than $25
   - Health or hospital insurance premiums or coverage change
   - Child care need or provider changes
   - Change of address and shelter costs
   - Child support expenses paid
   - Change of persons in the home

   My specialist will notify me if my reporting requirements change. If I have any doubt about whether to report a change, I will ask my Family Independence Agency specialist.

3. **Social Security Numbers.** I understand that the social security number is required by federal law (42 USC 1320b-7) for all persons applying for assistance. If I do not have a social security number for each person, the agency will help me apply for one. I understand that if I apply on my own, including at the hospital at the time of my child's birth, I must provide the social security number to the agency immediately after receiving it. Failure to do so may result in an overpayment which I must repay. If applying for CDC only, providing your social security number is voluntary and may

be used for establishing identity, tracking and report purposes. Aliens who cannot get a social security number may still qualify for Medicaid emergency services.

4. **Child Support.** I understand that I have the right to claim good cause for not cooperating in establishing paternity and obtaining child support and that cooperation is not required to get Medicaid for children or pregnant women.

5. **Domestic Violence Waivers of Program Requirements**. I understand that if certain program requirements (such as working, looking for a job, or going to school) would put me in danger of physical, emotional or sexual abuse, expose me to further harm or unfairly penalize me, waivers may be available. More information about these waivers is available from my specialist if I am interested in program requirements which may be waived. You are authorized for domestic violence comprehensive services. Contact your specialist or local FIA to access these services.

6. **Hearings**. I understand that if I do **not** agree with any decision made on any matter concerning my case, I have the right to ask for an administrative hearing. I understand that I can ask for information about an administrative hearing by calling the local Family Independence Agency office and that I can request an administrative hearing by writing to the local Family Independence Agency office. For Food Assistance benefits, I may request an administrative hearing in person, in writing or by telephone.

   I understand that if I want someone else to request a hearing for me or represent me in a hearing, that person must first have written authorization to do so unless that person is my attorney, or for Medicaid only, my spouse. The Family Independence Agency administrative hearings must have one of the following:

   - my original signed statement authorizing the person to request a hearing; **or**
   - a copy of the court order naming the person as my guardian or conservator.

   Otherwise, my hearing request will be denied.

7. **Food Assistance Benefit Rules**. I understand that if my household receives Food Assistance benefits, it must follow the rules listed below. I will also follow the instructions for reporting changes as described in Item 2 of these Acknowledgments. If my household holds back information about changes on purpose, it will owe the value of any extra Food Assistance benefits received as a result. If any information is found to be inaccurate, I may be denied Food Assistance benefits. I may also be subject to criminal prosecution for knowingly providing false information. Any member of my household who breaks any of these rules on purpose can be barred from the Food Assistance program for 1 year for the first violation, 2 years for the second violation, and life for the third violation; fined up to $250,000, imprisoned up to 20 years, or both; and subject to prosecution under other applicable federal laws. A court can also bar an individual from the Food Assistance program for an additional 18 months.

   - **DO NOT** give false information, or hide information, to get or continue to get Food Assistance benefits.
   - **DO NOT** trade or sell Food Assistance benefits or Bridge Cards.
   - **DO NOT** use Food Assistance to buy ineligible items, such as alcoholic drinks and tobacco.
   - **DO NOT** use someone else's Food Assistance benefits or electronic benefits cards for your household.

   If any member of my household is found guilty in court of the trading of controlled substances (drugs) for Food Assistance, that member will be barred from the Food Assistance Program for 2 years for the first offense and life for the second offense. If any member of my household is found guilty in court of the trading of firearms, ammunition or explosives for Food Assistance, that member will be barred from the program for life. If any member of my household is found guilty

of trafficking Food Assistance of $500 or more, that member will be barred from the program for life. Any person who obtains Food Assistance benefits in 2 or more cases at the same time will be barred from the Food Stamp program for 10 years.

8. **Fraud disqualification**. I understand I can be prosecuted for fraud if I intentionally make a false or misleading statement or misrepresent, conceal or withhold facts for the purpose of establishing or maintaining my group's eligibility or increasing or preventing reduction of benefits.

   Any person who is found guilty of fraud, pleads guilty to fraud or waives legal rights concerning an allegation of fraud will be barred from the Family Independence Program or State Disability Assistance program or Food Assistance Program for 1 year for the first violation, 2 years for the second violation, and life for the third violation. A person who is convicted of having made a fraudulent statement regarding his residence in order to receive assistance simultaneously in 2 or more cases shall be ineligible for the Family Independence Program for 10 years from the date of conviction. Assistance includes programs funded under Title IV-A of the Social Security Act, Medicaid, Food Stamp benefits and Supplemental Security Income. These special penalties do not stop you from receiving medical assistance.

9. **Repayment of benefits**. I understand that any adult in the household at the time a benefit overpayment occurs is responsible for repayment of any extra benefits received from FIA. This does not apply to Agency errors in medical assistance.

   A Food Stamp Authorized Representative may also be responsible for repayment of any extra Food Assistance benefits received in error.

   If an overpayment occurs, the information on this application, including Social Security Number, may be referred to Federal, State and private agencies for collection actions.

10. **Investigations**. I understand that my application might be one of those chosen for a complete investigation and that a Family Independence Agency representative might call at my home and might contact other people in order to verify my eligibility for assistance.

11. **Computer cross-checking**. I understand that the information I give on this application will be verified by computer cross-checking with other public and private agencies.

    The information obtained through this cross-checking may be verified through collateral contact when discrepancies are found. The information may affect both my eligibility for and the level of my benefits.

    Wages reported by my employer(s) to the Michigan Department of Consumer and Industry Services will be checked against wage information I report to the Family Independence Agency. My social security number will be used to check this information. Throughout the year, my social security number will also be checked with other sources such as the Internal Revenue Service (IRS), unemployment compensation, and the Social Security Administration concerning income or assets.

    Information may be disclosed to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law if I am receiving FIP and Food Assistance. This does not apply to medical assistance.

12. **Medical Information**. By signing the application form, I understand that the Family Independence Agency and Michigan Department of Community Health, may get and use* necessary medical information about me or any of my wards or my minor children, including any information relative to HIV, ARC, or AIDS if applicable. This information will only be obtained and used as necessary to determine eligibility for a specific program or for other program administration purposes.

    *Some examples of uses are with auditors, caregivers, etc. State law (MCL 333.5131(8)) provides that a person who shares HIV, ARC, or AIDS information except as authorized by signed

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release or by law may be found "guilty of a misdemeanor punishable by imprisonment for **not** more than 1 year or a fine of **not** more than $5,000.00, or both, and is liable in a civil action for actual damages or $1,000.00, whichever is greater, and costs and reasonable attorney fees."

13. **Immunizations (Shots) For Children**. If my household is eligible to receive Family Independence Program benefits, I understand that the amount of those benefits will be reduced by $25.00 for each month any of my children under the age of six (6) are not immunized as recommended by the Michigan Department of Community Health.

14. **Child Development and Care (CDC)**. I understand that:

- I am responsible for any child care costs not paid by the agency, including benefits which may have been authorized but for which I no longer qualify, based on a change in circumstances.
- I am not eligible for child development and care benefits before the need exists or before the Agency receives this signed application.
- If a reported change results in a reduction in services, the reduction will be made as soon as administratively possible by the agency without advance notice.
- If approved for CDC, I may only use child care services during the times that I and all other parents/substitute parents in my home are unavailable due to employment, high school completion classes, approved education and training activities and approved activities for a health or social condition.
- To be eligible for CDC payment, I must use an eligible child care provider who is licensed/ registered by Child Day Care Licensing, Department of Consumer and Industry Services, or enrolled by FIA. Eligible providers are:
  - licensed child day care center.
  - licensed group day care home.
  - registered family day care home.
  - FIA-enrolled day care aide who must provide the child care in the home where the child lives.
  - FIA-enrolled relative care provider who must provide the child care in their home and
    - is an adult grandparent, great grandparent, aunt, uncle or sibling of the child needing care, and
    - does not live in the same home as the child.
- If I use a day care aide, I am the employer and responsible:
  - to discuss health and safety issues such as: emergency phone numbers, storage of poisons, handwashing, diapering, discipline procedures and immunization records with the aide.
  - for the employer's share of any employer's taxes which need to be paid.
- My day care aide or relative care provider will not be enrolled, and will not receive payment, or will stop receiving payment if they report, or a criminal background check shows, that they have been convicted of specific felonies.
- My day care aide or relative care provider will not be enrolled, and will not receive payment, or will stop receiving payment if they (and/or for relative care providers, any adult reported as living in their home,) are on the Central Registry as a perpetrator on a confirmed Children's Protective Services case.
- As a condition of eligibility for CDC:
  - it is my responsibility to pursue other benefits for which I may be eligible, such as child support, unemployment benefits, etc., and,
  - I must cooperate in child support actions.